

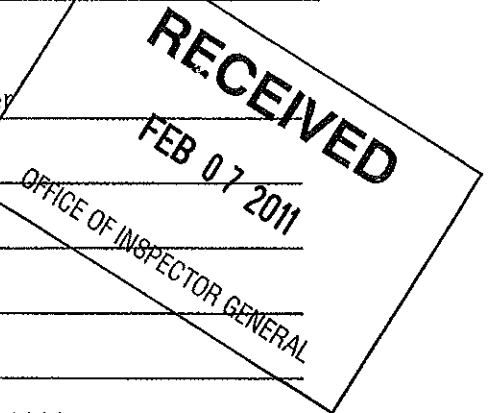
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 2-7-11
Amount \$1960.00

emailed validation letter 2/25/11
Ch# 00025403

I. IDENTIFICATION

Name McCreary Health & Rehabilitation Center
Address U.S. 27 and Hwy 592; 58 Cal Hill Road
City/County/Zip Pine Knot, KY 42635
Telephone number 606-354-3155
Administrator Sam Hutchinson
Date facility operation began at current address June, 1990
Date facility began operation under current owner July, 2005



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>60</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

III. CONTROL (check one in each column)

State	_____	Profit	<u>X</u>	Individual	_____
County	_____	Nonprofit	_____	Partnership	_____
City	_____			Corporation	_____
Private	<u>X</u>			LLC	<u>X</u>

IV. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

McCreary Health & Rehabilitation Center, LLC

9510 Ormsby Station Road, Suite 101

Louisville, KY 40223

(OVER)

2/28

If facility owned or leased by a corporation, complete the following:

Name of corporation United Rehab Realty Holding, LLC
Address of corporation 10350 Ormsby Park Place, #300, Louisville, KY 40223
President or Chairman _____
Ex. Vice President T. Richard Riney and Raymond Lewis
Secretary T. Richard Riney
Treasurer Brian K. Wood, Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.


If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>Senior Care Operations Holdings, LLC</u>	_____
<u>9510 Ormsby Station Road #101</u>	_____
<u>Louisville, Kentucky 40223</u>	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

<u></u>	<u>Vice President</u>	<u>1-27-11</u>
Signature of authorized representative	Title	Date
Robin L. Barber		

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)